Northgate School District Health and Emergency Form
(for specific extracurricular activities and overnight trips)

Name of Activity/Trip			
Dates of Activity/Trip	, 20	**To**	, 20
	Month, Day		Month, Day

Student's Name: _____ Grade:_____ Date of Birth:_____
Last First Middle

Home Address: _____ State:_____ Zip Code:_____

	Mother/Guardian	**Father/Guardian**
Name		
Home Phone		
Work Phone		
Cell Phone		

EMERGENCY CONTACTS: List individuals who are willing to transport your student, in order of preference if you cannot be reached.

1) Name		Phone		Relationship	
2) Name		Phone		Relationship	

Health Insurance Company:_____

Group Number: _____ ID Number:_____

Student's Physician:_____ Phone:_____

Student's Dentist:_____ Phone: _____

In case of an emergency requiring immediate medical treatment, I give my permission for the transport of this student to the nearest medical facility. If an ambulance is necessary, the closest available service will be called. If possible, an attempt will be made to contact the parent/guardian prior to transporting an injured or ill student. Payment for ambulance service to transport the student will not be the responsibility of Northgate School District or associated booster organizations.

_____ _____

Signature of Parent/Guardian Date

Please complete the reverse side of this form.

MEDICAL HISTORY

Please indicate below any of the following conditions that are applicable to your child. If none of these apply, please indicate that at the bottom of the sheet.

1) **Life-Threatening Allergies**: __YES / NO_ To What:_____
   If so, does your child have an Epi Pen prescribed by the physician? _____
2) Environmental/Food Allergies or intolerances: _____
   _____
   Asthma _____ Triggered by: _____
___If so, does your child carry an inhaler? _____ Type: _____
___Used approximately how often each day?_____
_____
_____
___Nebulizer treatments (type and frequency): _____
_____
3) Seizure Disorder _____ Date of last seizure: _____Symptoms demonstrated:_____
4) Diabetes _____ Insulin dependant? _____Usual Glucometer readings: AM____ Before meals ____ Bedtime _____
5) Chronic joint/muscle problems:_____
   Please specify where, reported symptoms and usual treatment:_____
   _____
6) Abnormal Bleeding Problems: _____
7) Menstrual Problems _____ Describe: _____
8) Has your child been hospitalized in the past 6 months? _____If yes, please explain: _____
   _____
9) Social/Emotional Difficulties that affect daily behavior: _____If yes, please explain: _____
   _____
10) Other Conditions or additional information you would like to share: _____
   _____

NONE OF THE ABOVE_____

Medications

I agree that all medications that will be in my student's possession are listed below:

	Medication	Dose and Frequency	Reason for Administration
1)			
2)			
3)			

I give permission for my student to self administer these prescription and/or non-prescription medications. I, and the student, understand that distribution of any medication to others is in violation of the Northgate School District medication policy and will cause the student to be subject to disciplinary consequences.

The chaperones carry a limited supply of the non-prescription medications listed below. I give permission for my student to receive, if necessary, the following medication(s) according to recommended product doses.

☑ Please note with a check mark those medications for which you give permission

	Tylenol		Immodium		Sudafed		Robitusin DM
	Ibuprofen		Benadryl		Dramamine		Tums

_____ _____ _____ _____

Signature of Parent/Guardian Date Signature of Student Date

All areas requiring signatures must be signed by the Parent/Guardian and Student where indicated.